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Ministry of Health and Long-Term Care

2nd Session
41st Parliament

Tuesday 14 November 2017

Chair: Cheri DiNovo
Clerk: Eric Rennie

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 14 November 2017

Mardi 14 novembre 2017

The committee met at 0902 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Welcome, everyone. Good morning. We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of six hours and 11 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meeting that the minister has responses to, perhaps the information can be distributed by the Clerk. Are there any items, Minister?

Hon. Eric Hoskins: There are not.

The Chair (Ms. Cheri DiNovo): When the committee last adjourned, the government caucus had 17 minutes remaining in their rotation. Ms. Hoggarth?

Ms. Ann Hoggarth: Just before we get started, I wanted to find out some information. According to the standing orders, I don't think that we can meet this afternoon because what's going on in the House will be of the same topic that we'd be talking about.

The Chair (Ms. Cheri DiNovo): The Ministry of Health?

Interjections.

The Chair (Ms. Cheri DiNovo): So what I gather is that I can ask if this is the will of the committee, then, to adjourn after this morning and just come back tomorrow afternoon.

Ms. Ann Hoggarth: Yes.

The Chair (Ms. Cheri DiNovo): Yes. Okay. So we will adjourn after this morning. Thank you.

Again, Ms. Hoggarth.

Ms. Ann Hoggarth: Our government developed the organ and tissue donation transplant systems to capture three main goals:

—maximize organ donations to increase organ transplants and to reduce wait times for organ transplantation;

—support an effective, efficient, safe and accountable organ and tissue donation and transplantation system; and

—meet the need for safe and high-quality tissue for transplantation in Ontario.

Since 2001, Ontario's organ and tissue donation and transplantation system has been coordinated and managed by the Trillium Gift of Life Network. Over 3.1 million Ontarians have registered to donate and that number is increasing every day. That's great news.

Minister, can you please advise what the status of the province's OTDT program is and what activities TGLN is doing to support organ donation?

Hon. Eric Hoskins: Yes. Good morning, everyone. I hope everyone had both a good long weekend as well as a productive constituency week.

I'm very pleased to speak about our success as a province, and our leadership that we're demonstrating, when it comes to organ and tissue donation. I'm extremely proud of the leadership at Trillium Gift of Life Network, including the long-standing chair of the board, Rabbi Bulka, who has been tremendous in growing that organization in terms of positive outcomes. Of course, I'd be remiss if I also didn't express my appreciation for the CEO of TGLN, Ronnie Gavsie.

The two of them and the team behind them have done an extraordinary job over the past number of years to help Ontario reach the point where we can be proud of the level of donations, including conversions, which is that important part where there is an eligible donor, to turn that eligible donor at that universally, I think, tragic moment in time, to work with the family and with health care providers to convert the possibility of a donation to an actual organ donation—as we all know, it is absolutely life-changing for those who are able to receive those donated tissues and donated organs—and to the point where last year, we saw yet again a record number of organ donations that took place in the province: 596 deceased and living organ donors helped to save the lives of 1,256 people through transplant. And that 596 is up from 577 the previous year. We're absolutely confident that we're going to break that record again this year.

The reason for that—there are many of them, I think—is we've fairly dramatically increased our funding to TGLN, understanding not only the reality that lives can be saved and dramatically transformed through the generosity of organ donation, but how science and technology have given us even more opportunity in that area.

It is also through a careful and principled adjustment of our approach that we've yielded greater success, by looking at other jurisdictions, for example, that have seen success both in terms of numbers of individuals registered—and that is an important aspect of it—but, importantly, also at that moment in time where that eligibility

needs to be carefully and sensitively transformed into actual availability.

In a moment, I'm going to ask Neeta Sarta, who is the director responsible in the ministry for overseeing TGLN and our organ and tissue donation and transplantation system—but I just want to touch on one element which has been introduced over the past few years by TGLN which I believe is absolutely at the foundation of our success of that second part that I mentioned, the conversion, turning eligible donors into actual donors, and that is modelled after other jurisdictions, particularly in Europe, where—

Interruption.

Hon. Eric Hoskins: I don't know if anybody else can pick that up. Somebody's on their way down to Queen's Park, it sounds like. I'm sure my microphone didn't pick that up, so I'm probably looking and sounding very strange right now.

What we've come to realize is that it's the team and, indeed, the individuals who are present in the hospital environment, where they have the opportunity to identify individuals eligible for donation of organ and tissue, at that extremely difficult and sensitive and tragic moment in time with the loss of a loved one—are able to work with the other health care providers, social workers and others, with the family, in a very careful and sensitive manner that respects the dignity of the individual, obviously, and respects the challenging circumstances the family is going through.

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Not always, but generally, what we do now is, we fund individual health care providers—doctors, generally—within those hospital environments, who take on the role of leadership within the hospital to harness all the resources and to ensure that this system is in place so there is maximum opportunity to convert an eligible donor, to obtain the consent of the family when an individual is deceased and is eligible or has expressed their wishes to be a donor.

So it's that in-hospital architecture, if you will, with the leadership of individuals who are charged with the task of harnessing the resources, providing the leadership and ensuring that every opportunity is availed, which has resulted—in other jurisdictions, and we're seeing it here in Ontario, as well—in a very substantial increase in that ratio, in the percentage of eligible donors who become actual donors. We're very proud that we're seeing, year after year, a substantial increase in the number of donors and lives saved. It's through steps like that, making the necessary investments, and through steps like ensuring that the public has easy access to be able to register as a donor as well and understanding that their commitment to donate can in most cases save up to eight lives. It's that combination of public awareness and ease of access, if you will, to be able to register, combined with an infrastructure, with the leadership—as I mentioned, with Rabbi Bulka and Ronnie Gavsie and her team, and the infrastructure and the leadership that exists across this province to provide the necessary organs for a world-class health care system, with specialists, transplant surgeons and their teams, who do an absolutely exceptional job and are demonstrating global leadership and are so talented, who are able to then avail themselves, on behalf of their patients, of those opportunities.

Despite all that success, we still have a long way to go. It's always a work in progress. There are too many individuals in Canada, including in Ontario, who die on the wait-list, regrettably, waiting for an appropriate organ for transplantation. That's unacceptable. It drives us, and I know that it drives Ronnie and Rabbi Bulka, to be the best that we can be, and ensures that we're not resting on the laurels of our success to date. Quite frankly, as long as there's one individual who dies on that wait-list, that's one individual too many.

Ms. Ann Hoggarth: Just before you pass it over, I wanted to say that I'm very proud of this program. My third cousin Gerry Shanahan donated the first heart that was transplanted here in Ontario many, many years ago. And my son-in-law got right to the point where he was at the hospital being checked for matching and everything, and someone else was chosen. So this program is very important to my family. I thank you very much for all the work that has gone in to this.

I think MPP Kiwala had something to say, too.

Ms. Sophie Kiwala: Yes. You mentioned the terminology "conversion" in your discussion this morning. It's a word that means an awful lot to the system in general and to the donation process, but what it means on the ground is something extremely important.

Just a couple of weeks ago, a friend in Kingston lost their daughter in New Zealand. While she was here, she had signed her card. The only thing that meant anything to that family was the fact that she had signed that card and she saved at least two lives. So it's pretty important, the work that we're doing here in Ontario, and it's obviously having an impact across the province. Thankfully, in this particular case, and because the level of information exchange was sufficient, she was able to make the kind of difference that she wanted to make in her life.

I can't say enough good things about this program.

Hon. Eric Hoskins: Thank you for sharing that. There are so many stories across the province. We hosted here at Queen's Park just a couple of weeks ago TGLN, the Trillium Gift of Life Network, and heard remarkable stories, both from donors and recipients. You're absolutely right: In a moment of such tragedy, it infuses an element of positivity, of being able to make some positive out of such a difficult and tragic circumstance. We heard that from individuals who were courageous and spoke to it here at Queen's Park quite recently.

That physician model in hospital is critically important, because it allows us also, I think, to create a culture of donation within the hospital environment itself, so everybody is thinking about that and looking for what their role is to encourage that. It needs to be seen as part of end-of-life care and options. Obviously, organ donation isn't suitable or appropriate under all circumstances,

depending on the age and medical condition, but it certainly needs to be explored.

It's critically important that families understand the wishes of their loved ones, whether they've registered or not. Hopefully they've registered on the organ donation registry. Regardless, it's vitally important that that conversation happens as early as possible, but if not early, certainly when you're having those end-of-life discussions. I know the circumstance that you described didn't allow for that discussion to take place, but the family was able to ascertain the daughter's wishes because she had registered.

It's a system that I think we can be proud of here, but again, we need to continue to build it. That's why when you look at the levels of funding that we've provided, we've almost doubled our funding since 2013. That is a recognition of how important this is to society as well as to individuals' lives.

Dr. Bob Bell: Minister, do you mind if I make a comment on this?

The Chair (Ms. Cheri DiNovo): First, just introduce yourself.

Dr. Bob Bell: Deputy Minister Bob Bell.

Since perhaps we won't have all the time that Neeta was looking for—Senator Sanders reminded us a few weeks ago that Canadians don't talk enough about the excellence of our system. This is an area, organ transplantation, where Ontarians literally lead the world in outcomes. If we look at lung transplantation, the work that's been done at Toronto General under their surgeon-in-chief, Shaf Keshavjee, who the minister knows well, has doubled the number of lung organ transplants because of the ability to provide regenerative medicine opportunities to lungs that were previously discarded as not being healthy enough for transplant—so literally twice as many people. As the minister knows, lung transplant patients, people needing lung transplants, are the most frequent to die on waiting lists. We've doubled the number of lung transplants in Ontario over the last five years based on the work that Keshavjee has led.

The Chair (Ms. Cheri DiNovo): You have just over a minute, Deputy Minister.

Dr. Bob Bell: The other area where Ontario is leading is induction of tolerance following liver transplantation. A collaboration between Toronto General and the Ottawa Hospital has led to patients who have stable liver transplants on immunosuppression getting subsequent bone marrow transplantation in Ottawa. It's been done five times so far, and four of those patients have been able to come off all immunosuppressive drugs, which would be just one of the most dramatic steps forward in transplant history.

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Ontarians can be extremely proud that in these two most frequent areas, apart from renal transplants of organ transplantation, that research and research being brought into practice in Ontario has resulted in truly international leadership, with people coming here from around the world to learn how Toronto and Ottawa care providers are caring for their patients—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up.

Dr. Bob Bell: Thank you.

The Chair (Ms. Cheri DiNovo): We now move to the official opposition. Mr. Harris?

Mr. Michael Harris: Minister, speaking about Bernie Sanders's visit, I noticed Premier Wynne and him. Were you part of that delegation or on that tour?

Hon. Eric Hoskins: Regrettably, I didn't have the opportunity.

Mr. Michael Harris: Not feeling the Bern?

Hon. Eric Hoskins: I've got great respect for Senator Sanders, and I think he's doing Canada a great service by educating Americans about the quality of health care they can expect to receive in this country.

Mr. Michael Harris: Very good. On October 25—Suzanne, I'll probably get you to come up, if you don't mind—I asked you folks a question on how many pan-Canadian Pharmaceutical Alliance negotiations have reached an agreement for 2017 to date, as well as for the last several fiscal years. I'm hoping by now you've got a bit of an answer there.

Hon. Eric Hoskins: Yes, I think we have that information.

Mr. Michael Harris: You can get me the information through research or whatever later, but I'm just kind of curious. If you can give me even just 2016 almost through 2017, how many—what is the actual terminology? Once someone's given the green light, what is it actually called?

Dr. Bob Bell: Maybe I can just start off by saying that sometimes, when negotiations take a long time, it's because we have a target as to what we think is an appropriate price to pay for the drug that's being negotiated. That's based on evidence, and sometimes that's the reason why it takes a long time.

Mr. Michael Harris: I get that that's the case, but there's obviously a significant funnel, right? Naturally, if there is that lengthy duration, I would imagine in 2016 you'd have something that would come through that may have been started, say, in 2013, 2014 or 2015. So in 2016, can you tell me how many were given a positive list final negotiation? We're not going to get into specific names, but just tell me numbers, perhaps.

If you want to give me a name, that's fine too, because I know you're extremely bright on this file. I've heard your name a lot, and I want to thank you. I know it's a tough gig out there on this particular file, but I know you perhaps agree with me that more can be done. Every day, people are waiting for—obviously Health Canada has their approval, but the negotiations at the pan-Canadian Pharmaceutical Alliance, people look at every day. I'll let you answer.

Ms. Suzanne McGurn: Thank you very much. Suzanne McGurn, assistant deputy minister and executive officer for the Ontario Public Drug Programs.

I know you asked about 2015-2016, but your previous question covered—

Mr. Michael Harris: Whatever you've got the numbers for.

Ms. Suzanne McGurn: I'll provide some additionals. In 2017-18—so, this current year until the end of October—the number of negotiations that were successfully concluded, which means an agreement was reached, has been 23 so far this fiscal year. That includes a number of high-profile products, including, for example, Avastin, for colorectal cancer; Basaglar, which is a biosimilar for diabetes; other medicines for leukemia; Humira, for ulcerative colitis; and Lenvima, for thyroid cancer.

The previous year, in 2016-17, we reached agreements for 41 products, and the year preceding that, 36 products.

I think probably what is most interesting—and you reflected on this as well—is that the actual number of products coming through is increasing. There has been an increasing number of health technology assessments, and in addition to health technology assessments, we may get a requirement to negotiate on a pan-Canadian basis from a product that was previously perhaps only funded in a single jurisdiction from a previous negotiation. In 2013-14—and I'm going to use these numbers because I think it does highlight, as you say, the growth—there were 38 products, growing to, in 2015-16, 69 products, and, as recently as 2015-16, to 94 products. This year, to date, it's 91.

For the duration of those negotiations, as the deputy said, they're highly variable. Again, the nature of the negotiation on both sides, including the way in which the manufacturer may have to respond to the negotiation process, can be quite complex. The average time is nine months for the negotiation process to be completed. There are negotiations that are as short as a few weeks to those that we have been unable to reach a negotiation on.

One of the things that I would say is probably different in this most recent year is that—we have tried in the past to stay at the negotiation table for an extended period of time, even where we were very far apart. It has not, in many cases, allowed us to achieve a negotiated outcome. We are now trying, where possible, if we cannot get close enough to an agreement, to close a file off and allow folks to revisit the topic and—particularly the manufacturers—to make a determination of whether there is additional evidence or additional value they can bring to the negotiation.

Mr. Michael Harris: All right, thank you. With regard to OHIP+, there has been a lot of back-and-forth, a lot of questions, particularly from the rare-disease community that have private coverage, that are accessing private treatments that are not perhaps easily accessible from Trillium. There was a bulletin that came out from the ministry recently that if somebody was to come to a pharmacy on January 1, and that particular pharmaceutical or treatment wasn't on the formulary but they had private coverage, the private insurer will then pay for the first six months. Is that correct?

Ms. Suzanne McGurn: On Friday of last week, we sent out an OHIP+ bulletin. It speaks to the transition period between OHIP+ launch and individuals who may have approval for their private insurers. What happens typically in a private insurer circumstance is that they would need to have a rejection from the drug program for drugs that we do not cover. The same would be in place for seniors. What has been arranged with the insurers, for a short period of time, is to make sure that individuals do not have disruption in their access; that the insurers will pay for a certain list of products that would have a very low approval rate for OHIP anyway, or a circumstance where any delay in access may be challenging—for example, a particular type of blood-thinning product that may be required. In those circumstances, there has been an arrangement made with the insurers, and they will not allow a gap in service.

There are many other products. With the majority of the other products, we are working with the private insurers to contact their recipients as well as clinicians, to be able to get them to pre-submit those types of products that would typically be approved by OHIP+, so we can get as many of them done as possible.

Mr. Michael Harris: The minister has talked about how, come January 1, if you are under 25, the province will be the first payer. That arrangement obviously has changed. How would those private insurers be compensated? What is going to be the financial arrangement with those folks who will then be covered by the private insurer until the OHIP+ kicks in, which is supposed to be effective January 1?

Ms. Suzanne McGurn: OHIP+ is effective January 1. The discussions with the insurers are unique to them, and the way in which we will be working with the insurers during that time period is to mitigate against any unnecessary administrative burden for either organization in support of being able to transition those individuals. We do think that those numbers will be quite small, particularly as OHIP+ continues to roll out.

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There's significant encouragement being given to clinicians etc., to familiarize themselves with the formulary, as well as to patients, to be able to ask questions of their clinicians in advance. So we do hope that those will be a fairly small portion.

Again, it demonstrates the commitment of the private insurance industry to be able to have a smooth transition to OHIP+.

Mr. Michael Harris: Right. I know my colleague is back, and he'll want to jump in to continue on.

Peter, I would like a quick update from the original questions I asked you about St. Mary's capital on electrophysiology. Perhaps you wouldn't mind giving me an update as to where things are at with that since we last chatted. Thank you.

Mr. Peter Kaftarian: Good morning. Peter Kaftarian, assistant deputy minister of the health capital division, Ministry of Health and Long-Term Care.

As to the status update, since we last talked, I had a follow-up from the hospital CEO himself, saying that for this expanded scope they had proposed to add in—they

would prefer not to move forward with that expanded scope right now.

We're just in the process of finalizing the functional program, which is the second stage of our process, to get them into design, to move the originally proposed project forward to the next stage.

Mr. Michael Harris: Any timelines as to when they'll have a go-ahead? I guess there's a letter that's received—

Mr. Peter Kaftarian: Yes. The letter would come from myself. The timelines would be ideally, hopefully, for the end of—soon.

Mr. Michael Harris: "Soon" being?

Mr. Peter Kaftarian: Well—

Mr. Michael Harris: We've been down this road before.

Mr. Peter Kaftarian: Yes. If we can, before Christmas would be ideal to move into the next stage.

Mr. Michael Harris: When would it be your expectation that they would actually have a spec ready that would go out for tender, or do you have a revised completion date? The minister was in in 2016 and said the fall of 2017. Do you have an updated expected completion date, by chance?

Mr. Peter Kaftarian: I'd say that once we are able to formally move them into design, then things can move quite quickly, but this is a key stage right now that we need to get through. Ideally, if we can get them into design by Christmas, then they can get into tenders by next calendar, by next year.

Mr. Michael Harris: By 2018, with completion, hopefully, by 2019 at the latest?

Mr. Peter Kaftarian: I don't want to give a specific date because we're still in the early stages, and I know you'll probably, at the next estimates, or tomorrow, hold me accountable to it.

Mr. Michael Harris: As we should; right?

Mr. Peter Kaftarian: These are estimates. I think the key thing was changing, getting clarity on the scope, and they've come back. The CEO is now clear on what their expectations are, so now we can really try to push this forward.

Mr. Michael Harris: Excellent. Okay.

Mr. Yurek?

The Chair (Ms. Cheri DiNovo): Yes. Mr. Yurek.

Mr. Jeff Yurek: Thanks, Chair.

Mr. Michael Harris: Thank you, Peter.

Mr. Jeff Yurek: Good morning. Last year, the Auditor General's report found that the government had not established an overall strategy and budget to guide the implementation of the entire eHealth initiative. Has the government since established a budget for which certain benchmarks must be achieved?

Hon. Eric Hoskins: We have, and we have a strong strategy and a 10-point plan to back that up as well.

We benefited from the work approximately a year ago, you might recall, that Ed Clark did, looking at digital health in the province, but specifically looking at the digital health assets of eHealth and the work they had done, and helping us, on a forward-looking basis, to map out what the best leverage of eHealth's talent, expertise and infrastructure should be.

I know that my deputy is very close to this file, so perhaps I can ask him to expand on some of the elements of that strategy, if you'd like.

Dr. Bob Bell: Super. Greg Hein, from our digital secretariat, is here as well.

This is a 10-point plan, Mr. Yurek, which is designed around consumer digital health, as well as providing integrated information at point of care for providers.

Some of the examples of the consumer digital health approach would be to make health information available to patients. Some examples of this would include the MyChart patient portal, which was started at Sunnybrook hospital and is now being used more widely by other hospitals to get access to hospital information. As well, other hospitals, such as the University Health Network, are making different portals available.

In addition to that, the ministry's been engaged with eHealth Ontario and public health units across the province in implementing e-yellow cards. You all know those yellow cards—that we all lose 42 times during the course of our kids' upbringing—that everybody's got in their drawers for their kids, documenting their immunizations. We now have that information recorded on a repository called Panorama, and parents who want to get access to their kids' immunization status, as well as their future needs for immunization, can get this information on their iPhones through connection with their public units, where this information is stored.

Those are two examples of the direction toward digital consumer e-health that the minister has led. The other is the development of a very new and fresh website, ontario.ca/health, which really provides Ontarians with information about how to use the health system. It provides them a lot of information about health system performance and wait times in a way that's much more rational and easier to access than the multiple sites that used to provide information. Integrating that information in one place, we think, is important and is part of the consumer digital health strategy.

When it comes to the provider digital health strategy, the real focus is on the integration of information at point of care. In the London South West LIHN—London region as well as Hamilton, throughout the entire southwest of the province—the availability of ClinicalConnect, which is a resource that brings together drug information, brings together lab information, diagnostic imaging information, as well as hospital information to hospital providers or to primary care providers in their office through a single sign-on mechanism, is really changing the kinds of information that Ontario clinicians have available to them at point of care. We're looking at expanding this. This kind of resource is available across the GTA now, and it's phasing into northeastern Ontario as well as the Champlain area.

There's nothing that makes care safer, as you know, than having information about patients. One of the big

additions to the available information at point of care is the digital drug repository information which has come online over the past six months that gives information about all publicly provided drugs as well as all narcotics to providers at point of care. That has been a large step forward, especially with respect to the opioid crisis that we're responding to.

The strategy is well-described. It has 10 points, and, if you like, I could ask Mr. Hein to expand on the rest of that strategy.

Mr. Jeff Yurek: Do you have a budget number that you can share?

Dr. Bob Bell: We don't have a budget number for all the elements of the 10-point strategy, but I think it's fair to say that within the ministry's information management and eHealth Ontario's budgets, we're expecting to complete the program within that. Certainly, when we look at the budget line for eHealth in estimates, this year it's $458 million.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have two minutes left.

Mr. Jeff Yurek: The other question is, do you have a timeline of when you'll reach these strategy end points?

Mr. Greg Hein: Greg Hein, I'm acting—I'm deputy minister—assistant deputy minister for—

Interjection: That's good.

Mr. Greg Hein: Yes, I just gave myself a promotion.

We had a really positive, constructive engagement with the Provincial Auditor, and what they were interested in is how we flow funds directly from the ministry for digital health versus some of the more indirect ways through LHINs, and also how those expenditures go toward front-line business and clinical functions versus sharing information across providers, which is normally what's referred to as the electronic health record.

We agreed with their recommendation that we should figure out how to enhance the way that we monitor all of those different expenditures. I guess something that's really been an improvement over the last little while is having a digital health board, which the minister has delegated to the deputy. It includes a good cross-section of people from across the health sector to figure out the best way to maximize the investment that we're making in digital health. We also have an investment management framework to maximize the benefit of tax dollars.

0940

Mr. Jeff Yurek: How much time?

The Chair (Ms. Cheri DiNovo): You have 30 seconds—29, 28—

Mr. Jeff Yurek: Well, I'll be in the next rotation, but I appreciate the time and effort that you've taken today in answering some of my questions—even though it has only been one. I hope that my colleague Michael Harris had good success in his questions.

Hon. Eric Hoskins: Can I just add, in the remaining seconds, that you look particularly distinguished today.

Mr. Jeff Yurek: Go to Movember and donate to my cause. That would be great.

The Chair (Ms. Cheri DiNovo): And that is that. Thank you. We now move on to the third party. Ms. Armstrong.

Ms. Teresa J. Armstrong: Good morning, Minister and Deputy Minister. Thank you very much for being here today.

I particularly wanted to ask you about the PSW registry. Back in 2011, there was an original announcement made. I'd like you to talk about a history of what cost was entailed with that registry and why there was such a lack of success with it.

Now you've re-announced a new registry in 2017. In particular, in one of the announcements that was made, in a news release, the government specified that the "PSW registry will include a transparent complaints process for patients and families to report and resolve complaints involving PSWs."

I'd like to know what the process looks like, and also how you expect to enforce those complaints when people make them. Then I'd like to ask you what the estimated cost of the new registry is going to be. And have you taken steps to involve the ministry in order to make sure that the process of this new registry is going to be successful phase by phase, so that we don't end up with another failed registry like we did in 2011?

Hon. Eric Hoskins: Thank you very much for that multi-part question. I'll begin, at least, the best that I can, to answer it.

You're correct that a number of years ago, we began a process for creating a PSW registry. I think that all of us agree on the importance and that it's a very worthwhile endeavour to have that registry, so that the public, as well as the professionals who call themselves PSWs and those who employ them, can all have confidence in the mechanism for hiring and know that there's a credentialing that takes place to provide that confidence.

As you're aware, in 2016, I directed the closure of the existing PSW registry. It was following a review I had initiated both on the program side as well as the financial side of the organization that was providing the registry at the time. I asked for a review, and the results of that review suggested that it didn't achieve the level of confidence that was required, particularly in terms of the vetting process that would result in an individual being on the registry itself. So it was closed and the data that had been gathered to date was archived.

You're correct that earlier this year, we announced that the Michener Institute would be asked to create a PSW registry of the sort that would be useful to PSWs and potential clients as well as employers. That's the work that we're undertaking. We estimate that in the current fiscal year, we've set aside $2.1 million for that purpose.

Deputy, are there other elements that perhaps you might be able to begin to address as well?

Dr. Bob Bell: Yes, thank you. Ms. Armstrong, the issue of complaints is one that—within our current system of regulated health professions, when a professional is covered within a college system, there's a well-

established complaints process. However, in this case, these are unregulated health providers, and this is more complex. But it's certainly something that needs to be understood and managed, as personal support workers become an essential part of the health care system, both in home care and, of course, in long-term-care and retirement homes. We need a better understanding. These folks are looking after people in very intimate, private settings, obviously—their own homes. So understanding the professional aspects and the professionalism of these people, even though they're not in a college, is an essential part.

The Michener Institute's leader, Dr. Brian Hodges, is an internationally recognized expert on health care education and professionalism. As part of his role of developing the registry at the Michener Institute, we've asked him to also provide us with advice as to how we should register and investigate complaints when we don't have the context of a college setting. We're anticipating that with the launch of the registry, which we think is going to start registering its initial candidates in January 2018—within this fiscal year, as the minister said—we would also have the early stages of a consultation approach to how we're going to manage the complaint process, how we're going to look at the potential for removing somebody from the registry and making the registry a very reliable resource for Ontarians to use when they're looking at who is providing care for their loved ones.

Ms. Teresa J. Armstrong: I appreciate the financial piece on the new registry going forward. I did want to ask what the cost was of the previous registry, for developing that, which didn't come to fruition.

Hon. Eric Hoskins: The previous registry, despite best efforts, didn't reach the level of confidence—and that's not to say that it didn't have utility. But we felt that an independent third party taking a more rigorous approach was the best path forward. For 2013-14, it was just over $1 million for the previous registry; 2014-15 actuals were $2.5 million; and 2015-16 actuals were $2.1 million.

Ms. Teresa J. Armstrong: Wow.

My next question is, in order to avoid this reoccurring under the new provider that you've accessed, what are your techniques or mechanisms to follow this and have oversight to ensure that it actually is going to deliver what it promises and be a success at the end? Do you have an idea of how long this will take to be completed?

Hon. Eric Hoskins: The work has begun. We expect elements of the registry will begin to come together over the course of the next calendar year, in a more fulsome manner—by 2019.

The question you asked, which is highly relevant, is precisely why we chose and in fact were advised by a number of authorities—the Professional Standards Authority of the United Kingdom, for example, which has engaged in similar work, strongly advised us to not house the registry within an association that might represent PSWs. They felt very strongly, as did other stakeholders and those we consulted with regard to best practices, that it was critically important that an independent third party take on this responsibility—one that has the capacity and the ability to take a very rigorous, best-practices, evidence-based approach to this, which is what Michener is well known for and will undertake for us—so that, in terms of the decision that we made.

That also allows us to have absolute confidence that there is no—not that there would necessarily be a conflict of interest, but that there doesn't need to be a shift of any entity, in terms of between the PSWs themselves and advocating on their behalf and advocating on behalf of patients and clients. We wanted this squarely to be patients first and clients first. We believe that we've found the right mechanism. The advantage of our relationship with the Michener Institute is it allows for tremendous accountability from the ministry—and work with the ministry, together with Michener, to ensure that, again, those best practices and that rigorous approach and the oversight and accountability is provided.

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Ms. Teresa J. Armstrong: When would be the first opportunity that the ministry is briefed on the progress that's made for this new registry?

Hon. Eric Hoskins: Do you want to introduce yourself and then go ahead?

Ms. Denise Cole: Denise Cole, the assistant deputy minister for health workforce planning and regulatory affairs. I am the ADM that's accountable for, I would say, the success of the registry.

We are working quite closely with the Michener Institute. I am the executive sponsor for the project. We are in daily contact with the Michener Institute as development is moving forward so that we are building on the lessons learned from the review that the Professional Standards Authority did.

In terms of the arrangement with Michener, there is a transfer payment agreement in place that holds the Michener accountable in terms of not just delivering on the development of the registry but the outcomes we want to see in the registry. It's not a hands-off approach that we're using; we're in very close contact, and there is a working group that has been established.

Ms. Teresa J. Armstrong: One last question: This is maybe pre-empting it too much, but if the registry doesn't work properly—is there any particular agreement that you wouldn't provide final payment for that service if you don't get the product that you're asking for? It is in there?

Ms. Denise Cole: Absolutely; that's part of the transfer payment agreement.

Ms. Teresa J. Armstrong: Was that in the previous agreement, by chance, with regard to the economic value that was spent on that registry?

Ms. Denise Cole: Yes, there were deliverables, but I think it's important to point out that registries are new to Ontario. The PSW registry, the first one—it was new in terms of establishing it. There was a transfer payment agreement in place with the previous organization that

hosted the registry. There were years when there were funds recovered. In particular in the final year, all the funds that were earmarked in the transfer payment agreement were not expended.

Ms. Teresa J. Armstrong: Thank you. I'm going to let France have an opportunity to ask a question.

The Chair (Ms. Cheri DiNovo): Madame Gélinas.

M^me^ France Gélinas: Thank you, Denise. I will change a bit. I'm coming back to Healthy Smiles Ontario. We all know that kids from parents on OW or ODSP are eligible. I would like to know: How many children and youth who are not receiving social assistance are eligible for Healthy Smiles Ontario, and how many of them are enrolled versus the total number that includes those children? Do we have that?

Dr. Bob Bell: Roselle Martino is the ADM responsible for public health.

Ms. Roselle Martino: Roselle Martino, assistant deputy minister of the population and public health division.

There are 460 children and youth eligible, Madame Gélinas.

M^me^ France Gélinas: Four hundred—

Ms. Roselle Martino: Four hundred and sixty thousand children; sorry.

M^me^ France Gélinas: The 460,000 children—those are the ones whose parents are not receiving ODSP or OW? They are low-income. Of the eligible, how many are enrolled? Of the 460,000, how many of them enrolled?

Ms. Roselle Martino: Three hundred and ninety-eight thousand as of July 31 of this year. This number could increase, potentially.

M^me^ France Gélinas: Okay. How does this compare to the number of children before the program was rolled out, when we had CINOT and Assistance for Children with Severe Disabilities and HSO and all of those? How do those numbers compare once we exclude OW and ODSP?

Ms. Roselle Martino: It actually is much better. There's a significant increase. One of the things that Minister Hoskins was really adamant about was that nobody fell through the cracks, so the integrated program actually puts in a mechanism to ensure that children that were receiving services through the other patchwork of programs continue to receive those services, as well as those who were coming onboard new. It actually expanded the eligibility for children in participation of the program.

M^me^ France Gélinas: I understand. I want it quantified. There are 460,000 eligible; 398,000 have enrolled. How many were eligible before we had this, when we had the patchwork, excluding OW and ODSP?

Ms. Roselle Martino: I have to get the number.

M^me^ France Gélinas: Okay, thank you. Of the 398,000 that had enrolled, how many have received treatment? And again, that excludes social assistance and ODSP.

Ms. Roselle Martino: It would be the 398,000 children receiving treatment.

M^me^ France Gélinas: Okay, so everybody that has enrolled has received treatment?

Ms. Roselle Martino: Yes, and there are different forms of treatment—whatever the spectrum is with the basket of services. Those children would have received some treatment, yes.

M^me^ France Gélinas: This is kind of odd. All 398,000 have received treatment this year or in the two years that the program has been going on?

Ms. Roselle Martino: At some point, because the treatment is continued, right? They might have to have a cleaning every year, for instance. Once they are eligible, up until they're 17, they're eligible. They are in the program at that time.

M^me^ France Gélinas: Do we keep track of who is receiving treatment?

Ms. Roselle Martino: Yes, we do.

M^me^ France Gélinas: Can I have them by any lapse of time? Every three months, or every year? How do you keep your stats on who is receiving treatment?

Ms. Roselle Martino: We do have a process through our third party, through our claims administrator, but I can take the request back to break it down.

M^me^ France Gélinas: Thank you. I know that the government had earmarked $100 million for Healthy Smiles. How much went to the administration of Healthy Smiles, like billing for claims and the work that Accerta is doing for you?

Ms. Roselle Martino: Approximately $12 million.

M^me^ France Gélinas: $12 million? And how is this $12 million broken up? It all goes to Accerta for the claims?

Ms. Roselle Martino: It's the transfer payment agreement with Accerta, yes.

M^me^ France Gélinas: Okay. Does that include the total cost for Accerta, no matter the number of claims that they handle for the government?

Ms. Roselle Martino: Yes, that was the transfer payment agreement, and that's what it is.

M^me^ France Gélinas: Okay. And are there any evaluation programs in place, or evaluation efforts to make sure that Healthy Smiles does what we want it to do?

Ms. Roselle Martino: Yes, absolutely. There is a comprehensive evaluation program in place to look at not just is the policy doing what it was intended to do, but also looking at the impact of the program, given the variants of dental care use across the province.

M^me^ France Gélinas: Do we have enrolment and eligibility by geographical area or by LHIN, or do you keep it province-wide?

Ms. Roselle Martino: Again, I'll have to take the request back. We do have the ability to break it down. Just a reminder that there are fee-for-service dentists that participate; that is one tranche of clients that are served. Then there are the public health dentists and clinics. We have different models of offering the service, and I can look at it and take the request back in terms of how we can break that down.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have just over two minutes.

Hon. Eric Hoskins: Can I just add as well—

M^me^ France Gélinas: Yes, sure.

Hon. Eric Hoskins: You had asked about before and after, with the six programs and currently. I don't have the actuals, but the eligibility of the old program, of the six before integration, was 460,000 children, and as was referenced a few moments ago, it's 573,000 with the new program with regard to eligibility—so an additional 110,000, roughly.

M^me^ France Gélinas: Okay. Thank you. And if you keep stats, I would be interested in seeing, excluding OW and ODSP—of the 460,000 that are eligible and the 398,000 that actually enrolled, there is a gap between the two. I'm interested in finding out if the program is more accessible in some part of the area. I can tell you that I still have a very tough time in my riding finding dentists who would participate in Healthy Smiles.

Hon. Eric Hoskins: I'm being told that you have over 70 participating dentists in your riding of this, for Healthy Smiles.

M^me^ France Gélinas: I don't have 70 dentists in my riding. Maybe in the northeast, but—

Ms. Roselle Martino: We can get the numbers. There are quite a bit of dentists, not just in your riding, Madame, but in the area that serves your surrounding ridings as well. We can get the number of dentists.

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M^me^ France Gélinas: Thank you. But I would also like to know the difference between the 460,000 children and youth and the 398,000. Where are those 62,000 kids?

Hon. Eric Hoskins: Yes, that's a very important question. I'm happy to speak to the ministry about that and see if we can—

M^me^ France Gélinas: Okay. Thank you. I will let my 15 seconds go.

The Chair (Ms. Cheri DiNovo): We now move to the government side. Mr. Colle.

Mr. Mike Colle: Before I share my time with the member from Kingston and the Islands, Ms. Kiwala, I just have to ask you a question on behalf of my dentist, who's a constituent of yours, Minister. That's Dr. Bob Bennett, who is a long-time advocate for First Nations health initiatives and has worked internationally with Dignitas International. What he was very enthusiastic about was a program established in the Sioux Lookout area with Dignitas International for medical treatment for diabetes and diabetes prevention.

I know you've had other agreements with First Nations across Ontario. I know it's a very specific question, and I know the University Health Network—perhaps Dr. Bell may be aware of it—was set up in 2015 with a special agreement with the chiefs in the Sioux Lookout area, Dignitas International and the University Health Network. Sorry for the lack of preparation for this, but is there any information on that?

Interjections.

Mr. Mike Colle: Could you get it to me later?

Hon. Eric Hoskins: We'll see if we can begin to answer that—and then whatever we can't, we can endeavour to obtain that information.

Ms. Sharon Lee Smith: My name is Sharon Lee Smith. I'm the associate deputy minister of the Ministry of Health and Long-Term Care for policy and transformation. I have the honour of having the indigenous health file in my portfolio.

Sir, I'm not aware of the exact program and partnership you're talking about, but we are very close to Sioux Lookout staff, and I can do the follow-up on that. It may very well be that there is a partnership with the organizations you're talking about and us and the federal government. We are both in the space with respect to health programming, in particular diabetes. We are working to map out our programming together so we don't have gaps or overlap, but with respect to that program we can certainly follow up and look at the details.

Diabetes is a scourge in the First Nations communities, as you know. It is a very serious issue, and as part of our Ontario First Nations action plan, diabetes is one actual tranche of the work that we are doing, and we are going to be putting in significant funding in the order of $20 million over the next couple of years to make sure that we are supporting both First Nations in communities and indigenous people in the urban area who have diabetes, but also working to promote healthy living and healthy choices so that people can avoid becoming diabetic.

It is a problem in our province in general, but unfortunately for First Nations people—First Nations, Métis and Inuit—diabetes is very, very prevalent, and we are working through our plan to address it.

Mr. Mike Colle: Just in conclusion: I know that the rate of diabetes is about four times higher in the indigenous community than it is in the general community.

Ms. Sharon Lee Smith: Yes.

Mr. Mike Colle: What's the reason for that? Are there any reasons why there's such a prevalence of type 2 diabetes in indigenous communities as there is—and I know in certain communities even in the GTA here, with the West Indian community and even other communities, I've heard there's a high rate of diabetes.

Ms. Sharon Lee Smith: I can say something general, and Minister Hoskins might want to answer as well. I'm not a clinician so I don't have the expertise with respect to a medical answer, but in part, lifestyle and access to treatment and access to healthy food that is priced appropriately, that is not overpriced and demeaning, because a lot of food in First Nations communities is just too expensive and not adequate—we do have a Northern Fruit and Vegetable Program which is part of our First Nations action plan. We are working to—sorry?

Hon. Eric Hoskins: Thirteen thousand more.

Ms. Sharon Lee Smith: Thirteen thousand more First Nations residents—adults and children—as a part of our northern fruit and vegetables initiative.

But in general we know we have to work harder with communities on this issue. We also need to work more

directly with the federal government as well. Diabetes is stealing time from children, and the amputation percentage is very high. Through dedicated health promotion and better public health supports to communities—we believe that's the answer. It isn't us just jumping into communities and saying, "You need to do this or that"; it's us working in a very culturally appropriate way with leadership, with health directors, to educate and bring solutions that are culturally safe and that work for First Nations people.

Mr. Mike Colle: Thank you so much. I'll pass it over to my colleague from Kingston and the Islands.

The Chair (Ms. Cheri DiNovo): Ms. Kiwala.

Ms. Sophie Kiwala: Thank you, Madam Chair. I'm very pleased to be chiming in on this First Nations question since I am the parliamentary assistant to the Minister of Indigenous Relations and Reconciliation. I've got a lot to ask you and I've got a lot to talk about so I'm just going to whip through what I have.

We have been working collaboratively to create a high-quality health care system that's equitable and responsible to all populations in our province, including those who live in the north. Minister, we know that this summer you signed a first-of-its-kind agreement with Nishnawbe Aski Nation and Health Canada, outlining a path to transforming the health care system for northern First Nations Nishnawbe Aski Nation territory. This agreement is a first step in the process to transform the current health care system, rooted in colonial values, into a future system where First Nations health care could be planned, developed and implemented by First Nations themselves. I can't stress enough how important that is, and it comes across in every single ministry that I work with.

Last year, our government also announced the largest investment in indigenous health care in the province's history. Minister, we know that health care is one of the most important issues facing this government and First Nations, Inuit and Métis—and indigenous communities in urban areas as well. We know that your ministry is involved in a myriad of programs geared to improving the health of indigenous people in Ontario. We've just heard about some of those programs: the $20-million investment in diabetes, the Northern Fruit and Vegetable Program that's being delivered through schools in the north. And there are quite a number of other initiatives related to Firth Nations health care that I'm very proud of.

I'm wondering if you can please inform us about what the ministry is doing to address the low health status of the indigenous population?

Hon. Eric Hoskins: Certainly, and thank you for the opportunity to discuss our partnership with First Nations and other indigenous communities, but particularly, as we're discussing First Nations communities, in the health sector. Coincidentally, actually, on Friday I will be in Timmins with the federal minister, Jane Philpott, who as you know has undertaken responsibilities for social programs in partnership with First Nations across the country. Jointly, Ontario and Health Canada are funding a health summit, which is what this activity on Friday is going to be, for NAN.

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This is really the first opportunity that we've had since signing that charter of relationship principles, which was a trilateral agreement together with the Nishnawbe Aski Nation, or NAN, Health Canada and Ontario. This will be the first significant and tangible opportunity we'll have to be able to gather with the NAN leadership, as well as front-line health care providers and health leadership within NAN, to discuss a whole myriad of health issues, including the high prevalence of diabetes—by the way, Sharon Lee was exactly right in her analysis of why the prevalence is as high as it is among First Nations communities.

That summit will give us an opportunity to deepen the discourse, consultation and discussion on a number of issues, including the continuing partnership with regard to the unprecedented investment of $220 million over three years—and subsequent to that three-year period, I think it's $104 million of ongoing investment. It is the largest single investment of its kind in First Nations health care in the history of the province, and targets all those important areas, including funding First Nations themselves so that they have the capacity to work with this, to better understand diabetes and diabetes management, and to develop strategies that are unique and appropriate.

A lingering question, I know, from the member from Nickel Belt is with regard to how we are also funding cultural competency training for front-line health care providers and administrators who work with First Nations communities. I know I was asked this question in the Legislature with regard to if that program, that cultural competency training which has already been completed with 8,000 front-line health care workers, will be available in both English and French. The answer is yes.

The reason why it had not yet been available in French language is because the London entity that is providing that training for us began as a pilot. As you can appreciate, it's important that that kind of cultural competency training—although there are good best practices out there, we wanted to make sure that we were delivering it in an appropriate, sensitive and effective manner. That pilot has now been completed, and it is absolutely the intention—I had asked; I don't yet have the precise timeline for it, but it will absolutely be provided in an individual's language of choice, whether that be English or French.

The Chair (Ms. Cheri DiNovo): Minister, you have under two minutes left.

Hon. Eric Hoskins: To get back to and maybe end with the charter of relationship principles, which I'm enormously proud of and so excited about—I know all of us in the ministry; Sharon Lee is nodding her head as well—this basically sets us on a path, in the first instance with NAN, but there is so much enthusiasm across First Nations communities and leadership across this province.

I'm confident that we're going to see similar charters of relationship principles, or whatever they might be called, that are unique and appropriate to First Nations, that will take us in partnership in a collaborative, sensitive way down a pathway that will result in a health care system for First Nations that is conceived of by First Nations, planned by First Nations, run by First Nations, implemented by First Nations, and evaluated and moderated by First Nations as well, a system which will—

Ms. Sophie Kiwala: Can I just interrupt for one second?

Hon. Eric Hoskins: Yes. It might be all we have.

Ms. Sophie Kiwala: I just wanted to make note that this is a trend that I'm seeing within this government that I'm exceptionally proud of. I worked as well on the changed legislation for the Child and Family Services Act, which is all centred on cultural practices that are geared towards children being the focal point, and First Nations children being the focal point as well. They are the drivers in those programs, so it's not only within the health ministry but it's also within other ministries as well. This is a direction that we absolutely need to be going in, as a government, towards working on real truth and reconciliation.

Hon. Eric Hoskins: We're so absolutely committed to it, and I'm proud of the fact that the federal government is equally committed to it as well.

Ms. Sophie Kiwala: Yes.

The Chair (Ms. Cheri DiNovo): That takes us to the closing time. We are adjourned now until tomorrow at 3:45.

The committee adjourned at 1015.

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